

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

✓ Do not use this space.

25093

**1. PLACE OF DEATH**

County.....  
Township.....  
City.....  
*St. Louis, Mo.*

Registration District No. *791*  
Priority Registration District No. *1003*  
*City Hospital # 2*

File No. ....  
Registered No. *7289*  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. *2935 Dayton 21* Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. *6* ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *male* 4. COLOR OR RACE *col* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *1-19-30*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
*5 22*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. *no occupation*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *mo.*  
(STATE OR COUNTRY)

**PARENTS**  
10. NAME OF FATHER *Fred. Paige*  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Alabama*  
12. MAIDEN NAME OF MOTHER *Ethel May*  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Arkansas*

14. INFORMANT *H. Gertrude Cratch*  
(Address) *City Hospital # 2*

15. FILED *JUL 22 1930* REGISTRAR *Walter Richter*

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *7-11-1930*

17. I HEREBY CERTIFY, That I attended deceased from *7-6-1930* to *7-11-1930*, that I last saw him alive on *7-11-1930*, and that death occurred, on the date stated above, at *11:40 A.M.*

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*malnutrition*  
*34*  
*158*  
*Syphilis* (duration) yrs. *4* mos. ds.  
CONTRIBUTORY (SECONDARY) *congenital* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *no* DATE OF  
WAS THERE AN AUTO SY? *no*  
WHAT TEST CONFIRMED DIAGNOSIS? *Clinical + lab.*  
(Signed) *H. C. Sampson* M. D.  
, 19 (Address) *City Hospital #*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL  
*St. Louis U.* *7-11 1930*

20. UNDERTAKER ADDRESS  
*Walter Richter* *3500 Putzgerst*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

